

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-041368

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318 SL 32337 EC Unknown

Primary Registration District No.

T003

Registrar's No.

10910

STATE FILE NUMBER

FILED NOV 15 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St Louis, Missouri		c. CITY OR TOWN Webster Groves	
Length of stay in lb 65 yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Vets Admin Hospital		d. STREET ADDRESS (If outside, give location) 639 Clark	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Devaney Last Devaney		4. DATE OF DEATH Month 11 Day 1 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/12/98
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) St Louis, Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME JAMES C. DEVANEY		13b. MOTHER'S MAIDEN NAME CATHERINE M. QUIGLEY	
14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO.		17. INFORMANT Josephine Devaney, Sister, (see 2 above)	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) Arteriosclerotic Heart Disease			
DUE TO (c) 4200			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) General Arteriosclerosis: Cerebral Arteriosclerosis Cerebral Vascular Accident, Old		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour 5 PM Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION St. Louis, Mo.		COUNTY St. Louis STATE Mo.	
21. <input checked="" type="checkbox"/> attended the deceased from 10/31/63 to 11/1/63 and last saw him alive on 11/1/63		Death occurred at 7:00 PM m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE G. Randolph (Degree or title)		22b. ADDRESS VAH, St. Louis, Mo.	
22c. DATE SIGNED 11/1/63			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	
23c. LOCATION (City, town, or county) ST. LOUIS MO.			
24. FUNERAL DIRECTOR Arthur J. Connolly		25. DATE RECD. BY LOCAL REG. NOV-4 1963	
26. REGISTRAR'S SIGNATURE Paul Smith M.D.			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

DATE AMENDED

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VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 4699

P. O. Address 384 Linden

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license):

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.